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Supreme Court of the United States

January Term, 1975

No. 74-1151

PLANNED PARENTHOOD OF CENTRAL MISSOURI, a Missouri Corporation, DAVID HALL, M.D., and MICHAEL FREIMAN, M.D.,
Appellants,

vs.

JOHN C. DANFORTH, Attorney General of the State of Missouri, and J. BRENDAN RYAN, Circuit Attorney of the City of St. Louis, Missouri,
Appellees.

No. 74-1419

JOHN C. DANFORTH, Attorney General of the State of Missouri,
Appellant,

vs.

PLANNED PARENTHOOD OF CENTRAL MISSOURI, a Missouri Corporation, DAVID HALL, M.D., MICHAEL FREIMAN, M.D., and J. BRENDAN RYAN, Circuit Attorney of the City of St. Louis, Missouri,
Appellees.

On Appeals from the United States District Court for the Eastern District of Missouri, Eastern Division

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BRIEF AS *AMICI CURIAE* FOR PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., ASSOCIATION OF PLANNED PARENTHOOD PHYSICIANS, INC. and CERTAIN MEDICAL SCHOOL DEANS, PROFESSORS and INDIVIDUAL PHYSICIANS

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Consent to Filing of Brief as *Amici Curiae*

Pursuant to Rule 42(2) of this Court, *amici* have obtained written consent from the attorneys for all parties to these cases to the filing of this brief as *amici curiae*.

Opinions Below

The opinion of the majority of the three-judge panel of the United States District Court for the Eastern District of Missouri, Eastern Division, and the opinion, dissenting in main, of Circuit Judge William H. Webster were rendered on January 31, 1975, and are reported at 392 F.Supp. 1362.

Statement of Interest of *Amici*

Planned Parenthood Federation of America, Inc.

Planned Parenthood Federation of America, Inc., also known as Planned Parenthood-World Population (Planned Parenthood), is a not-for-profit corporation organized in 1922 and existing under the laws of the State of New York. Its headquarters are in New York City. It is the leading national voluntary public health organization in the field of family planning.

Planned Parenthood has 188 affiliates in 45 states and the District of Columbia, all of them separate not-for-profit entities. These affiliates operate approximately 725 family planning clinics offering services to the public. Most affiliates offer medical services, including 19 which offer

abortion services as part of their program. Twelve affiliates are educational units without medical services. Most Planned Parenthood affiliates which do not perform abortions themselves offer abortion counseling and referral.

Planned Parenthood provides its affiliates with guidance in the areas of contraception, voluntary sterilization, infertility, abortion, sex education and education for marriage and parenthood. Each of the affiliates offering medical services functions under strict medical standards promulgated by the National Medical Advisory Committee in conjunction with local medical advisory committees. These committees are made up of health professionals, the large majority of whom are physicians.

Planned Parenthood also functions as a clearing house for information and services relating to these same areas. It formulates medical and clinical standards which are available to its affiliates and generally on a nationwide basis and develops guidelines and materials relating to public and professional education in all aspects of family planning. Its Medical Director and other consultants confer with other national medical organizations, medical school faculties and local agencies in relation to teaching techniques, formation of clinics and the like.

Many of Planned Parenthood's affiliates operate in cooperation with local public health facilities. The affiliates are also teaching and training centers for physicians, nurses, teachers and social workers from this country and foreign countries and provide referral services for their clients to qualified medical specialists and facilities.

In 1974, there were approximately 1,460,000 medical visits to Planned Parenthood clinic services. As part of these services, 26,800 abortions were performed. All of these were first trimester abortions which were performed at free standing clinics operated by Planned Parenthood affiliates.

The generally approved methods of abortion in the first trimester are suction (or vacuum aspiration) and dilatation and curettage (or D & C). See Tietze & Murstein, *Induced Abortion: 1975 Fact Book.* Reports on Population and Family Planning, No. 14, Dec. 1975 (2d ed. in press). These methods are not generally used after the first trimester (although it was recently reported that Dr. William Peterson, head of obstetrics and gynecology at the Washington, D. C. Hospital Center now performs suction abortions routinely up to the 16th week of pregnancy. *Intercom,* Vol. 3, No. 6, p. 11 (Population Reference Bureau)). Planned Parenthood believes that the medically approved techniques now in general use for abortions performed after the first trimester—saline abortion (intrauterine instillation of a saline solution), prostaglandin abortion, hysterotomy and hysterectomy—are most safely performed in a hospital setting. Such procedures are not performed at Planned Parenthood free standing clinics; Planned Parenthood affiliates refer patients to hospitals for abortion after the first trimester.

Planned Parenthood's concern with family planning and family health necessarily includes concern with the availability of abortion, including abortions performed after the first trimester of pregnancy, and with the compelling

problems resulting from restrictive abortion laws which have in the past made medically safe, legal abortions unavailable to many women. On October 19, 1974, the membership of Planned Parenthood adopted the following Policy Statement:

> "Planned Parenthood believes that the optimum method of birth planning is the consistent employment of effective contraception. However, in the event of unwanted pregnancy, abortion as a back up procedure must be available and accessible to all women.
>
> The Constitutional right of privacy includes a woman's right to seek an abortion. Planned Parenthood believes that a woman, in consultation with a physician, has the right to obtain an abortion under safe, legal, dignified conditions, and at a reasonable cost. A woman should be fully informed and counselled concerning the nature, the consequences, and the risks of the procedure. Under every circumstance, a woman should have full knowledge of the alternatives available to her when making a decision to continue or terminate a pregnancy.
>
> Abortion must always be a matter of personal choice. Planned Parenthood recognizes its responsibility to guard equally against coercion or denial in connection with a patient's decision about continuing a pregnancy. The Federation will exercise special vigilance in protecting the freedom of choice and the civil rights of those who are dependent upon either public or voluntary agencies and in protecting a woman's personal choice.
>
> No one should be denied abortion services because of age, inability to pay, or other economic or social circumstances. Public and private funds should be made available to subsidize the cost of abortion services for those who want, and need, but cannot afford them."

This commitment to the principle that safe abortions should be available to all who seek them is a necessary corollary of Planned Parenthood's activities in the area of contraception. While Planned Parenthood does not view abortion as an alternative to contraception, it recognizes that abortion services are essential to protect women where contraception is unavailable, where it has not been used for some other reason and where it has failed.

Each year a number of the patients in contact with Planned Parenthood affiliates experience unwanted pregnancies, sometimes due to contraceptive failure. Contraceptive technology has not developed to a point where there is any perfect contraceptive and many of the techniques available to particular women do on occasion fail. Consequently many unwanted pregnancies occur each year which do not involve failure to use contraceptives or lack of motivation on the part of the patient. Also, many women do not have adequate access to contraception, or when contraceptives are available do not use them effectively. There are approximately 3½ million women in the United States without access to contraceptive services (Planned Parenthood Federation of America Annual Report, 1974, p. 2, col. 2), and 35% of all births continue to be unwanted and mistimed. Alan Guttmacher Institute Report, July 1, 1973—December 31, 1974, p. 5. Throughout the United States many patients who experience unwanted pregnancies seek abortion services or referrals for such services from the Planned Parenthood affiliates.

Moreover, as will be shown in this brief, frequently women who experience unwanted pregnancies defer abortion until the second trimester. These are most apt to be (1) very young women; (2) older women who may regard a missed period as a menopausal symptom; (3) women who defer their abortions because of social problems related to poverty and minority background; and (4) users of the new medical technique of amniocentesis for the detection of genetic defects in the fetus—a technique which is effective only after the first trimester.

Planned Parenthood has a profound interest in vindicating the constitutional right of all women to abortion as established by this Court in *Roe* v. *Wade,* 410 U.S. 113 (1973) and *Doe* v. *Bolton,* 410 U.S. 179 (1973). It is concerned that in 1973, between approximately one-half million and one million women who needed abortions were not able to obtain them. Report of Alan Guttmacher Institute on *Provisional Estimates of Abortion Need & Services in the Year Following the 1973 Supreme Court Decisions,* p. 9. Planned Parenthood is also concerned that in 1973, there were 215,800 out-of-wedlock births to women under age 20; yet, of approximately 430,000 women under age 20 who were estimated to be in need of abortion services, 186,000 were unable to secure legal abortions. *Ibid.*

Planned Parenthood believes that the judgment below, unless overturned, will have the effect of preventing many women, in Missouri and in other states which have enacted or may enact similar legislation, from obtaining needed abortion services.

Association of Planned Parenthood Physicians, Inc.

Planned Parenthood works closely with the Association of Planned Parenthood Physicians, Inc. (APPP), a New York not-for-profit corporation organized in 1974. APPP is the successor to the American Association of Planned Parenthood Physicians, an unincorporated association which was organized in 1963. In 1974, APPP had 922 members, all of whom were physicians or other health professionals associated with family planning.

APPP was formed for scientific, educational and charitable purposes and specifically to promote the ongoing interest in family planning in order to improve the stability and health of the family through responsible parenthood.

The APPP believes that the decision to undergo legal abortion must rest with the individual woman and her physician. It shares Planned Parenthood's concern about the effect of the judgment below upon the practice of good medicine as well as upon the rights of women to receive medical treatment for abortion.

Medical School Deans, Professors and Individual Physicians

The more than 80 individual physicians who as *amici* subscribe to this brief all practice obstetrics and gynecology as their medical specialty or are responsible for the education of medical students and residents, some of whom are in training in the specialty of obstetrics and gynecology.

The physicians believe that certain provisions of the Missouri statute constitute an unwarranted governmental interference with the right of physicians to administer necessary health care in accordance with their best professional judgment. Of special concern to physicians are the provisions of the Missouri statute which prohibit, after the first twelve weeks of pregnancy, the method of abortion known as saline abortion, and which make it a crime for a physician to perform an abortion which is not necessary to preserve the life or health of the mother unless the physician first certifies "with reasonable medical certainty" that the fetus is not "viable" as that term is defined in the statute.

Planned Parenthood, APPP and the individual medical school deans, professors and physicians named above, by reason of their long experience in and knowledge of the field of family planning and abortion services, believe that they are in a unique position to aid the Court in its resolution of the issues raised in this case. *Amici* have assembled relevant and recent scientific findings which are discussed herein.

Statutory Provisions Involved

Appellants challenge the constitutionality of "House Committee Substitute for House Bill No. 1211," enacted in the State of Missouri on June 14, 1974, which regulates the decision for and the medical procedure of abortion (hereinafter "the Missouri abortion statute").

With respect to arguments on the merits, *amici* will discuss only those provisions of the Missouri abortion statute

which (1) require parental consent for abortions for unmarried minors; (2) prohibit saline abortions after the twelfth week of pregnancy; and (3) define "viability" (after which abortion is prohibited except to save the life or health of the mother), since these are the questions as to which *amici* believe they are in a special position to be of aid to the Court and to provide factual material.

Amici do, however, support the arguments developed in the appellants' brief that other provisions of the Missouri abortion statute are unconstitutional. Sections of the Missouri statute which *amici* believe to be unconstitutional include Section 3(2), requiring a special type of written consent of the patient for an abortion at all stages of pregnancy; Section 3(3), requiring the written consent of a woman's spouse to an abortion; Section 7, providing that in the event of a live birth resulting from an abortion not performed to save the life or health of the mother, the infant shall be deemed an abandoned ward of the state and the rights of the parent consenting to the abortion shall be terminated; and Sections 10 and 11, requiring the completion and maintenance by physicians of certain forms and records relating to abortion at all stages of pregnancy.

In addition to the statutory provisions listed above, all of which were sustained by the court below, the Missouri abortion statute contained a provision (Section 6(1)) prescribing a standard of care which a person performing an abortion must exercise for the protection of the fetus. This section also imposed criminal and civil liability for "failure to take such measures to encourage or to sustain the life of the child" when "the death of the child results" from such failure. This section of the statute was held unconsti-

tutional by the court below for failure to exclude the stage of pregnancy prior to viability. The Attorney General of Missouri has appealed from that ruling. *Amici* believe that Section 6(1) is also unconstitutional.

Summary of Argument

In this brief *amici* present research data, as well as legal arguments, to demonstrate:

(1) The requirement of the Missouri statute that unmarried minors must have parental consent for an abortion is not supported by a "compelling interest" and is overbroad because it does not exclude minors who are sufficiently mature to give informed consent. The state interests commonly relied upon in justification of parental consent requirements for abortion are not in fact advanced by such requirements.

(2) The statutory prohibition against saline abortions after the first twelve weeks of pregnancy unreasonably interferes with the right of physicians to practice medicine as well as their patients' rights to have them use their best professional judgment. This prohibition would have the practical effect of making abortions unavailable after the first trimester, which would have especially harmful effects upon three groups of women: (a) socially disadvantaged women, mainly young, black and poor, who for certain similar reasons experience delay in obtaining abortions; (b) women who wish to make use of the new technique of amniocentesis for the detection of genetic disease; and (c) menopausal women.

(3) The Missouri statute's definition of viability, in connection with the prohibition of abortion after viability except to preserve the life or health of the woman, is unconstitutionally vague because it does not notify physicians as to what conduct on their part is prohibited. *Amici* believe that the determination of viability must be left to the treating physician and that viability must be legally defined as requiring a minimum of 24 weeks' gestation.

ARGUMENT

POINT I

The facts do not establish the compelling interest necessary to support the Missouri statutory requirement of parental consent to abortion for an unmarried minor.

Section 3(4) of the Missouri statute requires the written consent of "one parent or person in loco parentis" of an unmarried woman under eighteen for an abortion unless the abortion is certified by a licensed physician as necessary in order to preserve the life of the woman. The constitutionality of that provision has been upheld by the court below.

Although this Court has not yet ruled with regard to a minor's right to an abortion, as the United States Court of Appeals for the Fifth Circuit recently said:

> "[A]pplication of the standard enunciated by the Court in *Roe*—the need for the right and the dire consequences of its denial—would certainly dictate the availability of the right to minors. Indeed, it would

> appear that all of the criteria of *Roe* apply with even greater force to an unwed pregnant minor: teenage motherhood involves serious consequences including adverse physical and psychological effects upon the minor and her children, the stigma of unwed motherhood, impairment of educational opportunities caused by the need to drop out of school, and numerous other social dislocations. The magnitude of the minor's interest in avoiding these consequences suggests that the developmental differences between adults and minors do not warrant denying constitutional protection to the minor's abortions.
>
> We therefore believe that the fundamental right to an abortion applies to minors as well as adults." *Poe* v. *Gerstein*, 517 F.2d 787 at 791 (1975).

This Court held in *Roe* v. *Wade, supra*, that, where fundamental rights are involved, regulations limiting these rights may be justified only by a "compelling state interest" and "legislative enactments must be narrowly drawn to express only the legitimate state interest at stake."

In *Poe* v. *Gerstein, supra*, the court pointed out that the state could arguably rely upon four interests to defend a statute requiring parental consent for abortion:

(a) preventing illicit sexual conduct among minors;

(b) protecting minors from their own improvidence;

(c) fostering parental control;

(d) supporting the family as a social unit. 517 F.2d at 792.

These interests have been discussed to varying extents in the numerous cases already decided on this issue—every one of which, with the exception of the decision ap-

pealed from, has held that parental consent requirements for abortion are unconstitutional.

Poe v. *Gerstein, supra;*
Word v. *Poelker*, 495 F.2d 1349 (8th Cir. 1974);
Planned Parenthood Association v. *Fitzpatrick*, Civ. No. 74-2440 (E.D. Pa., Sept. 4, 1975);
Baird v. *Bellotti*, 393 F.Supp. 847 (D. Mass.) U.S. appeal pending, 44 U.S. Law Week 3295 (1975);
Foe v. *Vanderhoof*, 389 F. Supp. 947 (D. Colo. 1975);
Doe v. *Exon*, CV 75-L-146 (D. Nebraska Nov. 3, 1975) (preliminary injunction issued);
Wolfe v. *Schroering*, 388 F. Supp. 631 (W.D. Ky. 1974);
Doe v. *Rampton*, 366 F.Supp. 189 (D. Utah 1973);
State v. *Koome*, 84 Wash.2d 901, 530 P.2d 260 (1975);
In re P.J., 12 Crim. Law Rep. 2549 (Mar. 28, 1973) (D.C. Super. Ct., Feb. 6, 1973).

Amici submit that there is no evidentiary support connecting a parental consent requirement for abortion with any of the interests set forth above.

A. The Requirement Will Not Prevent Illicit Sexual Conduct.

With respect to the popular notion that the availability of contraception and abortion has increased sexual intercourse among adolescents, studies have indicated little if any effect from the increasing availability of contraceptives on the incidence of premarital or extramarital sex relations; young people rarely seek contraceptive assistance until long after a pattern of sexual behavior is established. See, *e.g.*, Settlage, Baroff and Cooper, *Sexual Experience of Younger Teenage Girls Seeking Contraceptive Assistance for the First Time*, 5 Family Planning Perspectives

223 (Fall 1973); Robert C. Sorensen, *Adolescent Sexuality in Contemporary America* p. 303 *et seq.* (World Publishing 1973); Michael Schofield, *The Sexual Behaviour of Young People* (Longmans Green, London 1965). "In the face of the statistics on births out-of-wedlock it is naive and dangerous to argue that persons will refrain from sexual activity if birth control is unavailable." Stein, *Furnishing Information and Medical Treatment to Minors for Prevention, Termination and Treatment of Pregnancy*, 5 Clearinghouse Review 131 at 152 (1971).

Certainly, the statistics on sexual activity among teenagers are overwhelming. Nearly 2.4 million never-married young women in the United States aged 15-19—about 28% of all such young women—were estimated, as of 1971, to have had some coital experience. Kantner and Zelnik, *Sexual Experience of Young Unmarried Women in the United States*, 4 Family Planning Perspectives 9 (October, 1972). In a period of declining birthrates, out-of-wedlock births in the United States for women under 20 have continued to increase, numbering an estimated 150,000 in 1972. *Unwanted Pregnancy Among Single Teenagers*, A Report of Planned Parenthood Federation of America, Inc. at p. 3. Illegitimacy rates among teenagers have increased most sharply, and births to teenagers are becoming an ever larger proportion of all births. National Center for Health Statistics, DHEW (NCHS), *Interval Between First Marriage and Legitimate First Birth, United States, 1964-66*, 18 Monthly Vital Statistics Report, No. 12 (Supp. 1970); NCHS, *Summary Report, Final Natality Statistics, 1969*, 22 Monthly Vital Statistics Report, No. 7 (Supp. 1973); and P. Cutright, "Illegitimacy in the United States", 1920-1968,

in Commission on Population Growth and the American Future, *Demographic and Social Aspects of Population Growth*, C. F. Westoff and R. Parke, Jr. (eds.), Vol. 1 of Commission Research Reports, 1972, p. 375.

An attempt to turn this massive tide by requiring parental consent for abortion can only prove illusory and harmful.

B. The Requirement Will Not Protect Minors from Their Own Improvidence.

The consequences of an unwanted pregnancy can be disastrous for a teenage girl and her child. If the pregnancy is carried to term, both the mother and child face greatly increased medical risks. J. A. Menken, "Teenage Childbearing: Its Medical Aspects and Implications for the United States Population", in Commission on Population Growth and the American Future, *Demographic and Social Aspects of Population Growth*, C. F. Westoff and R. Parke, Jr. (eds.), Vol. 1 of Commission Research Reports, 1972, p. 331. *See* Day, *Factors Influencing Offspring*, 113 Am. J. Diseases of Children 179 (1967); Daniels, *Medical, Legal and Social Indications of Contraceptives for Teenagers*, 50 Child Welfare 150 (1971); Wallace, *Teenage Pregnancy*, Am. J. Obst. & Gynec. (Aug. 15, 1965); Grant, *Biologic Outcomes of Adolescent Pregnancy: An Administrative Perspective*, in Johns Hopkins Univ. School of Hygiene and Public Health, Perspectives in Maternal and Child Health (1970).

The child also has a greater chance of being physically abused or neglected if it survives. Gil, *Violence Against*

Children—Physical Child Abuse in the United States 109 (Harvard University Press 1970) (9.29 percent of abusing mothers in 1957 were younger than 20 years of age); U.S. Bureau of the Census, Current Population Reports, Previous and Prospective Fertility: 1967, 29, Series P-20, No. 211 (only 2.4% of mothers 14-44 were younger than 20).

The social consequences can be equally disastrous, as pointed out in the quoted language from *Poe* v. *Gerstein*, *supra*. Precipitate marriage, marital instability, poverty and dependency all attend an unwanted birth. According to one expert, pregnancy is the largest cause of school dropouts among teenagers in lower socio-economic groups. Hearings on S. 2108 and S. 2319 before a Subcommittee of the Senate Committee on Labor and Public Welfare, 91st Cong., 1st and 2nd Sess. 69 (1970).

In the light of these documented hazards, it cannot be "improvident" for a pregnant unmarried minor to consult a physician about an abortion. Surely, as pointed out in *Gerstein*, the physician is in a position to counsel the minor as to the physical—and the emotional—consequences of her decision.

Any concern about the minor's ability to make an intelligent decision is met by the common law requirement that the minor—like any other patient—must give informed consent to the procedure. This would require her to be sufficiently intelligent and mature to understand the nature and consequences of the abortion procedure. See *Baird* v. *Bellotti*, *supra*, 393 F.Supp. at 854-55; *Foe* v. *Vanderhoof*, *supra*, 389 F.Supp. at 955; *In re P. J.*, *supra*.

The court below stated that children as young as ten years old have sought abortions and a child so young "cannot be presumed capable of making a decision as profound as the abortion decision without proper advice and counsel of her parents or a person in loco parentis." 392 F.Supp. at 1371. But as pointed out by the dissent, the Missouri statute does not distinguish between ten-year-olds and mature minors who are capable of giving intelligent, informed consent. 392 F.Supp. at 1376-77.* It is therefore unconstitutionally overbroad.

Instead of protecting a minor from her own improvidence, the statute operates to give her parents an absolute veto power which may be exercised for any number of reasons unrelated to the minor's welfare. The statute allows parents to refuse consent even where their judgment is colored by personal religious belief which the minor may not share, whim, or even hostility to their daughter's best interests. In *Baird* v. *Bellotti, supra,* the court found, based on the testimony of plaintiffs' experienced expert, that some parents would insist upon the continuation of their daughter's pregnancy simply as a punishment. 393 F.Supp. at 854. In that case, the minor plaintiff's father had told her, in connection with the pregnancy of a contemporary friend, that if that happened to her he would evict her and kill her boyfriend. 393 F.Supp. at 850. In *State* v. *Koome, supra,* the father of the minor woman testified that his opposition to the abortion stemmed from his belief that continuing her pregnancy to term would deter her from becoming pregnant in the future. 84 Wash. 2d at 908.

* In Missouri, the right of minors to consent for treatment related to pregnancy (other than abortion) and venereal disease is expressly recognized by statute. RS Mo. §§431.061, 431.062.

Surely giving parents an absolute veto over their daughter's right to an abortion does not serve the interest of "protecting her from her own improvidence."

C. The Requirement Will Not Improve Family Relationships.

The court below upheld the Missouri statutory requirement of parental consent for abortion on the ground that "the state's interest in safeguarding the authority of the family relationship [is] a compelling basis for allowing regulation of a minor's freedom to consent to an abortion." 392 F.Supp. at 1370.

Amici submit that the facts do not justify this conclusion.

The interests of the state in fostering parental control and safeguarding the family unit are often advanced together in support of a parental consent requirement. These interests were carefully analyzed by the Court of Appeals in *Poe* v. *Gerstein, supra,* where the court found them inadequate on two grounds. First, the court said:

> "The fact that the minor became pregnant and sought an abortion contrary to the parents' wishes indicates that whatever control the parent once had over the minor has diminished, if not evaporated entirely. And we believe that enforcing a single, albeit important, parental decision—at a time when the minor is near to majority status—by an instrument as blunt as a state statute is extremely unlikely to restore parental control. * * * If a minor's pregnancy has fractured the family structure, imposition of a parental prohibition of abortion cannot reasonably be expected to restore the family's viability as a unit." 517 F.2d at 793-4.

Second, the court in *Gerstein* reasoned that, while the privacy of the family is constitutionally protected, this protection can be justified as much by First Amendment associational values as by "the inherent rights of parents". These associational values exist not merely to protect parental authority, but also to preserve the intimacy and autonomy of the family relationship from state intrusion.

This argument was developed in a recent Harvard Law Review Note which stated:

> "Where, as in the contraceptive context, individual interests of parent and child are likely to collide, protection of their shared relational interest assumes independent importance and should not be directed at reinforcing the values of parents alone, which result when a parental consent requirement is imposed, but rather at fostering autonomous intrafamilial resolution of controversies."
>
> Note, *Parental Consent Requirements and Privacy Rights of Minors: The Contraceptive Controversy,* 88 Harvard Law Review 1001 at 1018 (1975).

The court in *Gerstein* concluded:

> "Thus, enforcing parental control is not 'necessary' to maintain the integrity of the family unit; in fact, the integrity of the family structure could best be maintained without state encroachment upon the minor's fundamental right to abortion, if the state refrained from interfering with the family decision-making processes at all. The absence of a parental consent requirement would not portend the lack of parental input into the minor's abortion decision. Rather, in the absence of the statutory requirement, the family will resolve the problem in the manner by which the minor's problems are generally resolved: where the parent-child relationship is strong, the parent will have a great deal of input into the abortion decision; where the parent-child relationship has broken down, the parents will have less direct input. In any case, we believe that the importance of intrafamilial relationship and family privacy is sufficient to outweigh the state's interest in the enforcement of the parental prohibition." 517 F.2d at 794.

Amici have pointed out that parents frequently veto their daughter's abortion for insubstantial personal reasons unrelated to her welfare. This type of "parental control" surely does not deserve constitutional sanction, especially where its consequences are visited not only upon the daughter, but upon the new baby, which is brought into the world subject to the greatly increased physical and psychological risks documented above.*

To summarize, none of the possible interests advanced in support of a parental consent requirement for abortion meets the standard of *Roe* v. *Wade*. This is especially true because the Missouri statute treats abortion differently from any other medical procedure. The court below stated that "the requirement of parental consent * * * does not single out the abortion procedure, since it is the practice of hospitals and physicians to require that a minor's parent consent to other surgical treatment as well." 392 F.Supp. at

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* See pp. 16-17 *supra*. Additional studies have shown that, compared with legitimate children, illegitimate children suffer more frequently a variety of social, economic and health handicaps and are less likely to perform well at school. This is even more true for illegitimate children born to teenage mothers who are not prepared for parenthood either in terms of emotional or social maturity or of economic capacity. Sklar and Berkov, *Teenage Family Formation in Postwar America,* 6 Family Planning Perspectives 80 at 90 and sources cited in footnote 24 (Spring 1974).

1370. In no other context, however, is there a specific statute requiring such consent and in no other context does the failure to obtain parental consent result in criminal liability. Moreover, as pointed out above, other Missouri statutes expressly permit minors to consent to treatment for venereal disease and for pregnancy connected care (excluding abortion).

Finally, it must be said that one of the most tragic and devastating effects of a parental consent requirement is that it often has the effect of delaying a pregnant girl's abortion until the second trimester when the medical risks are far greater. Tietze & Murstein, *Induced Abortion: 1975 Fact Book*. Reports on Population and Family Planning, No. 14, December, 1975 (2d ed. in press). The statistics in the table reproduced at page 24 of this brief, *infra*, show that the methods used for abortions performed after the first trimester are far more hazardous than the suction or dilatation and curettage available in the first trimester. The difference is dramatic, with a death rate of 1.6 per 100,000 for the early abortions and a rate ranging from 15.4 (for saline abortions) to 61.3 per 100,000 for hysterotomy and hysterectomy. See also Tietze and Lewit, *Joint Program for the Study of Abortion (JPSA): Early Medical Complications of Legal Abortion*, Studies in Family Planning, Vol. 3, No. 6 (Population Council, June, 1972). Surely the state can claim no "compelling interest" nor indeed any interest at all in delaying minors' abortions until they reach the more risky second trimester.

POINT II

The statutory prohibition against saline abortions unreasonably interferes with the right of physicians to practice medicine and patients' rights to their physicians' best medical judgment; the facts about second trimester abortions and the women who need them.

A. The Statutory Prohibition Against Saline Abortions Unreasonably Interferes With the Right of Physicians to Practice Medicine and Patients' Rights to Their Physicians' Best Medical Judgment.

Section 9 of the Missouri statute challenged in this case flatly prohibits after the first twelve weeks of pregnancy "the method or technique of abortion known as saline amniocentesis whereby the amniotic fluid is withdrawn and a saline or other fluid is inserted into the amniotic sac for the purpose of killing the fetus and artificially inducing labor."

This section was upheld by the court below on the ground that the saline procedure is dangerous to the health of the pregnant woman. The court reached this conclusion although it was undisputed in the testimony that the mortality rate from use of saline is less than in childbirth.*

This provision of the Missouri statute represents an unprecedented and unwarranted attempt by a state legislature to decide what medical techniques a doctor may or

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* "Testimony at trial established that the mortality rate in childbirth is approximately twenty per one hundred thousand (Dr. Warren, Tr. 44; Dr. Kerenyi, Tr. 94); mortality with saline is approximately fifteen per one hundred thousand . . ." 392 F. Supp. at 1373.

may not use.* No exceptions are made for situations where the banned procedure may, in the physician's judgment, be the best or even the only method of abortion suitable for a particular patient.

Remarkably, the prohibited method of abortion is clearly not the most dangerous. A table prepared by the HEW Center for Disease Control shows that the mortality rate per 100,000 legal abortions performed in 1972 and 1973 for the various methods of abortion was as follows:

Method of Abortion	*Number of Abortions*	*Number of Deaths*	*Mortality Rate Per 100,000 Legal Abortions*
Suction/D&C	1,065,338	17	1.6
Saline	123,684	19	15.4
Hysterotomy/ hysterectomy	8,161	5	61.3
Other	5,380	1	18.6

Reported Deaths Associated with Legal Abortion in the United States, by weeks of Gestation and Method of Abortion, 1972 and 1973, U.S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control. *Morbidity and Mortality Weekly Report* 24, January 24, 1975.

Reprinted as Table 12, *Legalized Abortion and the Public Health*, Report of a Study by a Committee of the Institute

* Judge Webster, dissenting below, pointed out:

"It is conceded that prior to the enactment of this statute, a statute mandating the application of a prophylactic solution to the eyes of newly born infants was the only known attempt by the Missouri Legislature to interfere with medical judgment in maternity cases." 392 F.Supp. at 1378.

Obviously a statute mandating a generally accepted prophylactic procedure is entirely different from one *prohibiting* a procedure widely used and endorsed by the medical profession.

of Medicine, National Academy of Sciences, Washington, D.C. May, 1975, p. 74.

The above table shows that the surgical methods of abortion—hysterotomy and hysterectomy—are almost four times as dangerous as saline abortion. Yet Missouri prohibited neither of these methods. The singling out of saline abortion for a blanket prohibition suggests that what the Legislature had in mind was not the safety of the pregnant woman at all but that of the fetus. The injection of a saline solution almost invariably results in the expulsion of a dead fetus. *Legalized Abortion and the Public Health, supra* at pp. 21-22.

In *Doe* v. *Bolton, supra,* this Court struck down a number of procedural requirements for abortion of the Georgia statute such as the requirement of committee approval, the requirement of hospital accreditation and the requirement that the performing physician's judgment be confirmed by two other licensed physicians. This Court ruled that the woman's right to receive medical care in accordance with her licensed physician's best judgment and the physician's right to administer it were unduly burdened by such requirements.

The Missouri statute which prohibits saline abortions after the twelfth week of pregnancy is an even greater infringement upon the rights of the woman and the physician. The physician's right to practice his profession free from arbitrary governmental interference and the patient's right to have him do so are protected by the Fourteenth Amendment. *Roe* v. *Wade, supra,* 410 U.S. at 165; *Nyberg*

v. *City of Virginia*, 495 F. 2d 1342, 1344 (8th Cir. 1974); *Wensel* v. *Washington* (D.C. Super. Ct., No. 11004-74, Apr. 10, 1975); see also *Greene* v. *McElroy*, 360 U.S. 474, 492 (1959); *England* v. *Louisiana State Board of Medical Examiners*, 259 F. 2d 626, 627 (5th Cir. 1958), *cert. denied*, 359 U.S. 1012 (1959).

An identical statutory provision was declared unconstitutional by a three-judge federal court in Kentucky. *Wolfe* v. *Schroering*, 388 F. Supp. 631 (W. D. Ky. 1974). Pointing out that prostaglandin abortions were not readily available in Kentucky, and that hysterotomy was far more dangerous than either saline or prostaglandin abortion, the court ruled that "in order for there to be an effective, safe method, and one which is generally available for the performing of post-first trimester abortions, this section [prohibiting the use of the saline method after the first trimester of pregnancy] must be held to be invalid." 388 F. Supp. at 637.

B. The Practical Effect of Banning Saline Abortions Is to Make Abortions Unavailable After the First Trimester.

The majority in the court below based its ruling sustaining the prohibition of saline abortions upon the existence of the alternate method of injecting prostaglandin. Yet, as pointed out by Judge Webster in his dissent, prostaglandin "has only been available on a non-experimental basis for slightly more than one year. It is not now readily available. It too has counter-indications—for persons suffering from glaucoma and asthma." 392 F.Supp. at 1378. Moreover, side effects of prostaglandins at therapeutically effective doses include nausea, vomiting, diarrhea and fever.

ACOG Technical Bulletin, Induction of Mid-Trimester Abortion with Prostaglandin F2a (1974); MacKenzie, Hillier & Embrey, *Prostaglandin-Induced Abortion: Assessment of Operative Complications & Early Morbidity*, British Medical Journal December 21, 1974 at p. 683. A recent study of 122 patients who had prostaglandin abortions showed a 42.6% complication rate, and other recent reports include the observation that rupture of the cervix and cervical fistulas have occurred, perhaps with greater frequency than in saline abortions. Duenhoelter & Gant, *Complications Following Prostaglandin F2a—Induced Midtrimester Abortion*, Obstetrics & Gynecology, Vol. 46, No. 3 (September, 1975); Wentz, Thompson & King, *Posterior Cervical Rupture Following Prostaglandin-Induced Midtrimester Abortion*, American Journal of Obstetrics-Gynecology 118:210-217 (1974); Lowensohn & Ballard, *Cervicovaginal Fistula: An Apparent Increased Incidence with Prostaglandin F2a*, American Journal of Obstetrics-Gynecology 119:1057-1061 (1974). For all these reasons, saline injection rather than prostaglandin abortion is presently employed throughout the United States in approximately 75% of all abortions after the first trimester. Testimony to this effect was uncontradicted at the trial. See dissenting opinion of Judge Webster, 392 F.Supp. at 1378.

The State of Missouri offered no evidence that prostaglandin abortions are available to women in that state. The practical effect of the decision appealed from is to make abortion after the first trimester unavailable to women in Missouri in violation of their fundamental rights as set forth in this Court's decisions in *Roe* v. *Wade* and *Doe* v. *Bolton, supra.*

Although the percentage of abortions performed after the first trimester is low,* the problems which often cause women to seek such abortions are serious. *Amici* believe that it is desirable for women who seek abortions to obtain them at the earliest possible date, but they wish to direct the Court's attention to three groups of women who will suffer special hardship if abortions after the first trimester become unobtainable.

The first is the group of young women, mostly poor and many from minority groups, who form a large percentage of the women seeking late abortions. The second group, presently small in number but increasing in size so that it will be of increasing significance, consists of women who use the new technique of amniocentesis to detect whether the fetus they are carrying will be born with serious genetic disease. As will be explained below, this technique cannot be performed until the pregnancy has advanced beyond the first trimester. If second trimester abortions become unavailable, the potential of this valuable technique will not be realized. The third group is composed of older women who confuse the symptoms of pregnancy with those of menopause.

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* In both 1972 and 1973 about 83% of the abortions in the United States were performed in the first trimester. *Legalized Abortion and the Public Health, supra* at 22. As legal abortion services become readily available, the proportion of early abortions increases. See Tietze & Murstein, *Induced Abortion: 1975 Fact Book*. Reports on Population and Family Planning, No. 14, Dec. 1975 (2d ed. in press); New York City Three Year Abortion Report (1 July 1970-30 June 1973). (The total number of abortions performed in the United States during 1973 is estimated at 745,000. Report of Alan Guttmacher Institute on *Provisional Estimates of Abortion Need & Services in the Year Following the 1973 Supreme Court Decisions*).

C. Characteristics of Women Seeking Second Trimester Abortions

Women seeking second trimester abortions appear to share certain demographic characteristics and similar reasons for delay in obtaining their abortions. The delays fall into two main categories: (1) those delays caused by the woman seeking an abortion, and (2) procedural delays in the medical care system.

Tietze & Murstein state that "Late abortions occur most frequently among women of low socio-economic status, and especially among the youngest women. The strong inverse association of period of gestation and woman's age probably reflects the inexperience of the very young in recognizing the symptoms of pregnancy, their unwillingness to accept the reality of their situation, their ignorance about where to seek advice and help, and their hesitation to confide in adults. Economic considerations and, in many places, regulations prohibiting surgery on minors without parental consent also contribute to delays". Tietze & Murstein, *Induced Abortion: 1975 Fact Book*. Reports on Population and Family Planning, No. 14, December, 1975 (2d ed. in press).

In a study of over 66 institutions participating in a study from July 1, 1970 to June 30, 1971, it was found that the period of gestation which had elapsed prior to the abortion was inversely associated with the age of the woman at the time of her abortion: "the younger the woman, the more advanced her pregnancy; the older the woman, the earlier she had the abortion * * * the proportion of second trimester abortions was highest by far for the youngest

women (49%) and the lowest for women in their early 30's (20%) followed by a slight increase during the later years of the reproductive period." C. Tietze & S. Lewit, *Joint Program for the Study of Abortion: Early Medical Complications of Legal Abortion.* Studies in Family Planning, Vol. 3, No. 6, p. 102 (Population Council, June, 1972).

The suggestion in this study, that the frequency of late abortions among the young probably reflects their inexperience in recognizing the symptoms of pregnancy, their hesitation and financial insecurity, is further enunciated by Bracken and Swigar in a study of factors associated with delay in seeking abortions. They found that "women between the eleventh and twentieth weeks of pregnancy were significantly more likely to be less than 21, single, have 0 to 1 living child, be black, not have completed high school, and not to have used a contraceptive at the time of conception." They suggested that the effects of age, number of living children and marital status were relatively independent and additive, and thus a single woman who was under 21 and had no children was exceedingly prone to delay beyond the tenth week of pregnancy before seeking an abortion. Bracken & Swigar, *Factors Associated with Delay in Seeking Induced Abortions,* American Journal of Obstetrics and Gynecology 113:3, p. 301, June, 1972.

Another study found that three-quarters of the white women in the sample were aborted with suction, *i.e.,* during the first trimester, while almost half of the black women were aborted after saline infusion, leading the researchers to conclude that termination was accomplished earlier by white women. Slate and Newman, *Medico-Social Aspects*

of Pregnancy Termination, A Report of 893 Abortions, Journal of Albert Einstein Medical Center, Vol. 20, Autumn 1973.

A partial profile of women seeking second trimester abortions was recently released by New York City's Eastern Women's Center and reported in *Intercom,* a publication of the Population Reference Bureau, in its August/September 1975 issue (Vol. 3, No. 8) at p. 11. The Eastern Women's Center did 4,238 second trimester abortions in 1974. A random sample of 500 patients showed that 49% of the women were between 16 and 20 years old and 7% were between 13 and 15. Seventy-three percent had never been married, 16% were married and 11% divorced or widowed. A racial breakdown showed 69% of the patients to be white and 28% black. Of the total of 4,238 women served, only 68 (1.6%) were New York residents; the remainder came from 37 states and many foreign countries.

A recent study on *Legalized Abortion & the Public Health* prepared by a committee of the Institute of Medicine of the National Academy of Sciences describes additional research on the psychological, sociological and cultural factors involved in the decision to seek abortion. Recent work of Kaltreider examined the psychological factors involved in the delay of the decision to seek abortion until the second trimester. Kaltreider observed that women who delayed their abortions went through a period of denial of suspected pregnancy, procrastination and general emotional confusion. Nancy B. Kaltreider, *Psychological Factors in Mid-Trimester Abortion,* 4 Psychiatry in Medicine 132-133 (Spring 1973); see also H. R. Klein, *Anxiety in Pregnancy & Childbirth* (Paul B. Hoeber, Inc. 1950).

Dr. Thomas Kerenyi of Mt. Sinai Hospital in New York City and his associates interviewed random samples of 200 women obtaining D & Cs* and 200 women obtaining saline abortions in New York City hospitals from late 1971 to the middle of 1972. Kerenyi found that the second-trimester women were on the average 3.4 years younger than the D & C group, less educated, more frequently single, less often employed, and were more likely to be students. The women obtaining saline abortions were also more frequently pregnant for the first time (65% versus 44%), and thus less experienced at detecting and coping with pregnancy. While both groups expressed similar emotional reactions to the discovery of being pregnant, the women obtaining the later abortions were slower to master their feelings and proceed to action. Like Kaltreider, Kerenyi notes that in addition to ambivalence, denial of the pregnancy also seemed to contribute to the delay in seeking early abortion. Even though a large majority of both groups of women had regular menses, twice as many of the women obtaining D & Cs as salines consulted a physician after missing only one period. Thomas D. Kerenyi, Ellen L. Glascock, and Marjorie L. Horowitz, *Reasons for Delayed Abortion: Results of Four Hundred Interviews,* American Journal of Obstetrics and Gynecology 117:299-311 (October 1, 1973). It should be borne in mind also that a not insignificant number of women who seek abortions after the first trimester are those in their later childbearing years. Because many of these women experience irregular periods as a result of the onset of the menopause, many of them do not discover they are pregnant until the pregnancy is well advanced.

* Dilatation and curretage (done in first trimester only).

Finally, many women who seek an abortion find themselves enmeshed in a complex medical care system. If access to medical care is limited by age, ignorance, poverty or geography, abortion may be delayed into the second trimester while the woman attempts to master the necessary steps to obtain it. To the extent that pregnancy tests are difficult to arrange, information on abortion is limited, medical facilities are inaccessible, or pregnancy counseling is unavailable, some women will require the later procedure through no ambivalence or reluctance of their own. To date, though, no research has sorted out the extent to which such factors in the health care system influence the delay in obtaining an abortion.

Whichever of these factors is the cause—or if, as seems likely, the delay is caused by a combination of reasons—many of the women who seek abortions after the first trimester of pregnancy fall into a socially disadvantaged group. Denial of abortion to these women—the likely outcome if the judgment below is sustained—would magnify and compound the severe burdens which they already suffer.

D. Amniocentesis and Genetic Disease

"Of the four million infants born in the United States each year, approximately five percent or 200,000 are afflicted with disabling, hereditary birth defects." Friedman, *Legal Implications of Amniocentesis,* 123 U. of Pa. L. Rev. 92, 93 (1974). There is no need to cite authorities to document the burdens which defective newborns impose on families. These include medical and special care expenses, marital disruption, depression and neglect of sib-

lings, not to speak of the suffering and often death of the infants themselves.

Until recently, a couple at risk of having a child with a severe genetic disorder had two choices: to take that risk or to forego childbearing entirely. Many parents with one genetically defective child chose the latter course. See Report on *Legalized Abortion and the Public Health,* Institute of Medicine, National Academy of Sciences (May, 1975) and sources cited in footnote on page 103.

In recent years, amniocentesis and other diagnostic techniques have been used to identify an increasing number of severe genetic and congenital disorders of the fetus shortly after the first trimester of pregnancy. With prenatal diagnosis, and the opportunity to terminate an affected pregnancy by means of a legal abortion, many women who would otherwise have refrained from becoming pregnant can be helped to bear healthy children. The availability of amniocentesis and second trimester abortions probably results in a net increase in the number of live births. This is because (1) parents with one genetically defective child now feel that they can "risk" another pregnancy; (2) when a genetically defective fetus is aborted, the parents are likely to try again, so that a healthy baby is born rather than a defective one. Hence the overall effect of the availability of abortion may well increase live births among this group.

Amniocentesis is defined as "a technique for obtaining amniotic fluid by inserting a needle into the amniotic cavity. This technique may be performed in the early second trimester for purposes of detecting genetic defects • • •"

Battelle Columbus Laboratories, *Final Report on an Assessment of the Role of Research Involving Living Human Fetuses in Advances in Medical Science and Technology* to National Commission for the Protection of Human Subjects, Dep't of Health, Education & Welfare, March, 1975, p. 30.

The critical time for the performance of amniocentesis is between the 17th and 20th post-menstrual weeks of pregnancy. (Before that time, there is usually not enough amniotic fluid to obtain an adequate sample and injury to the fetus may result from an effort to draw some fluid.) See Friedmann, *Prenatal Diagnosis of Genetic Disease,* 225 Sci. Am., Nov. 1971 at 37. Once the amniotic fluid has been drawn, it is centrifuged to isolate cells which are then grown in a culture medium for two to four weeks. Since the length of time required to complete the procedure and analysis is four to six weeks, the pregnancy will inevitably be in the 20-22nd week before a final diagnosis is made. If abortion follows immediately, it will be late in the second trimester.

More than six thousand pregnancies have been monitored in the United States and Canada between 1967 and 1974 by means of amniocentesis. A survey shows that less than ten percent of the diagnoses disclosed an affected fetus, thus ruling out the choice of abortion for the great majority of parents at risk. The diagnostic accuracy was close to 100% and complication rates were about two percent. See Aubrey Milunsky, *The Prenatal Diagnosis of Hereditary Disorders,* Springfield, Illinois: Charles C. Thomas Publishers, 1973, p. 37, and Table 18 at page 106 of the Institute of Medicine *Report on Legalized Abortion &*

the Public Health, supra; see also M. Gertner, L. Hsu, J. Martin & K. Hirshorn, *The Use of Amniocentesis for Prenatal Genetic Counseling,* Bulletin of the New York Academy of Medicine, Vol. 46, No. 11, 1970, p. 116.

At present, certain chromosomal disorders and about fifty inherited diseases associated with enzyme deficiencies are amenable to prenatal diagnosis. The following brief description of two of these disorders is taken from the Friedman article in the University of Pennsylvania Law Review cited above.

Down's Syndrome (mongolism) is the most common congenital anomaly, having an incidence of one in six hundred live births. Ninety-five percent of all Down's Syndrome children are severely mentally retarded. Half have congenital heart disease.

Tay-Sachs Disease is an autosomal recessive condition characterized by blindness, severe mental retardation and death, usually before three or four years of age. It is most common in Jews of central and eastern European origin, among whom it has an incidence of one in every 3,600 births.

The *New York Times* on May 23 of this year reported an article in the May issue of the New England Journal of Medicine which stated that physicians can now sample fetal blood as well as amniotic fluid to detect hereditary blood diseases such as sickle cell anemia and Cooley's anemia. Sickle cell anemia affects one in 400 babies born to black Americans; its frequency is high in certain other groups, the evidence being that it is most common among people whose ancestors lived in areas with a high incidence

of malaria. Cooley's anemia, also known as beta-thalassemia, afflicts mainly people of Mediterranean, Middle Eastern and Southeast Asian descent. Both sickle cell and Cooley's anemia greatly shorten the life expectancy of their victims. *New York Times,* May 23, 1975, p. 38, col. 1.

Not all pregnant women will or need to seek screening of genetic disorders in the fetus, but those who can be identified as at risk of giving birth to an infant with a severe genetic disorder and who would consider an abortion if an affected fetus were detected can be greatly helped by such screening. These include pregnant women who: (1) previously had a child with a severe genetic defect if it is recognizable *in utero;* (2) have been identified as carriers of a chromosomal aberration or whose husbands have been identified as such; (3) have been identified as carriers of a severe metabolic disorder and whose husbands are also carriers; (4) have been exposed to infectious diseases, drugs or radiation that might be harmful to the fetus; and (5) are beyond 35 or 40 years of age and therefore run a greatly increased risk of having a child born with Down's Syndrome or other defects. At age 40-44 a woman's risk of having a Down's Syndrome baby is 23 times greater than the risk faced by a woman less than 20 years of age. After age 45, the probability of a Down's Syndrome child becomes one out of every 50 births. Institute of Medicine, *Report on Legalized Abortion and the Public Health,* p. 107.

On June 24, 1975, the *New York Times* reported that a committee of the National Research Council on June 23 endorsed the practice of genetic screening as a valuable aid to public health and deserving of nationwide use. A report was issued by the National Academy of Sciences,

parent body of the National Research Council, supporting the use of genetic screening on a voluntary basis to prevent needless suffering and human and economic waste. Yet such screening serves no purpose unless the pregnant woman has the option of obtaining an abortion if the test reveals abnormality.

The results of a major Government-sponsored study of amniocentesis for the detection of genetic defects were announced at the 44th annual meeting of the American Academy of Pediatrics on October 20, 1975. Sponsored by the National Institute of Child Health and Human Development, the study involved 1,040 women who had amniocentesis performed and 992 pregnant women who did not. According to a summary of the data, which were compiled by nine major medical institutions,* the study "showed no significant adverse effects on the women undergoing amniocentesis; and no significant differences in rate of fetal loss, prematurity, newborn status, birth defects or developmental status at one year of age."

Of the 1,040 women who had amniocentesis, 34 were found to have fetuses with an abnormality. In addition, 11 were found to have male fetuses each having a 50% risk of a disorder such as hemophilia or muscular dystrophy. Thirty-five of these 45 women elected to have abortions, including eight whose fetuses were identified as having the chromosomal abnormality that goes with Down's Syn-

* Children's Memorial Hospital, Chicago; Eunice Kennedy Shriver Center, Boston; Johns Hopkins School of Medicine; Mount Sinai School of Medicine; University of California at Los Angeles (Harbor General Hospital); University of California School of Medicine, San Diego; University of Michigan School of Medicine; University of Pennsylvania School of Medicine and Yale University School of Medicine.

drome. Seven of the 992 women who did not have amniocentesis had babies afflicted with Down's Syndrome. *New York Times,* October 21, 1975, p. 46, col. 5.

The Institute of Medicine's *Report on Legalized Abortion and the Public Health, supra* (at p. 107), cites figures showing the huge financial outlays associated with the care of children with severe genetic disorders. It takes an average of about $5,000-$6,000 per year to pay the cost of institutional care for a retarded individual. The 50,000 persons now receiving institutional care for Down's Syndrome alone represent an expense of $250-$350 million per year. The issue, however, is not one of dollars and cents but of social and psychological cost and suffering. The financial data alone tells only a very small part of the human tragedy represented by the birth of defective infants rather than healthy ones.

Unless the judgment below is reversed, abortions will for all practical purposes be unavailable in Missouri after the first trimester. This will not only prevent a group of especially disadvantaged women from obtaining needed abortions (see pages 29-33, *supra*) but could curtail the entire program of genetic screening and amniocentesis for the detection of genetic abnormalities. *Amici* believe this would be a tragic setback to medical progress.

POINT III

The definition of "viability" in the Missouri statute is unconstitutionally vague; the facts about viability.

Section 5 of the Missouri abortion statute provides:

> "No abortion not necessary to preserve the life or health of the mother shall be performed unless the attending physician first certifies with reasonable medical certainty that the fetus is not viable."

Section 2(2) defines "viability" as "that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems."

Section 14 makes any person who performs an abortion contrary to the provisions of the act guilty of a misdemeanor.

These three sections place upon the physician who performs an abortion a heavy burden, not imposed, so far as *amici* are aware, on any physicians performing any other medical or surgical procedures. As to a gestation of less than twenty-four weeks, the statute is so clearly unconstitutional under *Roe* v. *Wade* that *amici* will not in this brief go beyond stating that conclusion. With reference to abortions after more than twenty-four weeks of gestation, up to and including somewhere between the 24th and the 28th week of gestation, the requirement that the physician certify "with reasonable medical certainty" that the fetus is not viable is also clearly unconstitutional since the statute sets no firm or clear guidelines, and the physician

must determine the fact of viability or non-viability at his peril. However soundly his judgment is based, he can be second guessed by a judge and jury, and if they find that he was wrong, he is subject to criminal penalties. It is clear that in such circumstances physicians will be "chilled" into not doing an abortion at all unless the fetus is clearly of a gestation far less than twenty-four weeks. In other words, although *Roe* v. *Wade* held that during the period from the end of the first trimester to viability, the state may legislate only in the interest of the pregnant woman, the effect of the Missouri statute is to deter physicians from performing any abortions during this period.

Amici believe that the Missouri statute's requirements as to viability fly in the face of this Court's holding (as summarized by a three-judge court holding a Minnesota statute unconstitutional) that "as between cases the point of viability will vary, and whether or not the fetus is in fact viable must be left to the medical judgment of the physician. In any event, under present technology, it does not arise prior to twenty-four weeks." *Hodgson* v. *Anderson*, 378 F.Supp. 1008, 1016 (D. Minn. 1974), *app. dismissed sub nom. Spannaus* v. *Hodgson*, 42 L. Ed. 2d 832, Jan. 27, 1975.*

It is *amici's* position that viability may not be considered in connection with any pregnancy of less than twenty-four weeks' duration and that the physician's judgment as to viability after that cannot be made the basis of criminal liability if he should turn out to have been wrong.

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* This Court ruled that the appeal properly belonged in the Court of Appeals for the Eighth Circuit. Argument was heard in that court on May 12, 1975, and a decision is pending.

The determination which the physician is required to make during the period after twenty-four weeks is not a simple one. Indeed, a three-judge federal court which recently invalidated a similar definition of viability on constitutional grounds pointed out that "a preponderance of the evidence supports a finding that there is not a consensus within the medical community as to the gestational age at which viability occurs." *Planned Parenthood Association* v. *Fitzpatrick*, Civ. No. 74-2440 (E.D. Pa., September 4, 1975), slip opinion at p. 24.

Amici hereby offer for this Court's consideration research data showing that the diagnosis of viability is a complex predictive matter incapable of any precise or fixed definition and involving many factors in addition to gestational age. It is made extremely difficult by the limits on the information available to the physician at the time he must make the decision. "The physician's estimate of the weight of a 600-gram fetus *in utero* may be consistent with delivery of a 1000-1200 gram premature infant." Behrman & Rosen, *Report to the National Commission for the Protection of Human Subjects, infra,* at p. 23 (March, 1975). Yet the Missouri statute subjects the physician who performs an abortion to criminal penalties if a jury—after the abortion and with the benefit of a great deal more information about the fetus, including its weight and measurements—should decide that his decision that a fetus is nonviable (which he thinks he made with "reasonable medical certainty") was wrong.

A. The Scientific Data

The Report to the National Commission for the Protection of Human Subjects, prepared by Dr. Richard Behrman and Dr. Tove Rosen of the Columbia-Presbyterian Medical Center and a panel of distinguished consultants in March, 1975 (hereinafter referred to as the "Behrman-Rosen Report") contains a mass of statistics from all over the world about the survival rates of infants in relation to their birth weight and gestational age. Although it is not possible to summarize all of those statistics here, a few salient points should be noted:

In no instance did a reported infant survive who weighed less than 601 grams and was of a gestational age of 24 weeks or less. Behrman-Rosen Report, p. 27.* Where infants weighed 1000 grams or less, the chances of survival ranged from 1 in 276,531 (for a weight of 601-650 grams) to 1 in 14,554 (for a weight of 951-1000 grams). Behrman-Rosen Report, pp. 6-7. Despite major improvements in the technology and care of premature infants, an infant of 25 weeks' gestational age has no better chance of surviving than 3.6 out of 1 million. Behrman-Rosen Report, p. 12.

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* There is considerable variation in birth weight at different gestational ages. The following appears as Table 2 of the Behrman-Rosen Report:

Estimated Weeks of Gestation	*Recorded Birth Weights in Grams*
22	460-600
23	550-950
24	500-850
25	600-1000
26	400-925
27	630-1050
28	680-1000

Based on all their data, Drs. Behrman and Rosen formulated the following guidelines for viability:

> "A fetus or prematurely delivered infant is biologically viable when a minimal number of independently sustained, basic, integrative physiologic functions are present. In order for the fetus or infant to be viable the sum of these functions, considered together, must support the inference that the fetus or premature infant is able to increase in tissue mass (growth) and increase the number, complexity and coordination of basic physiologic functions (development) as a self-sustaining whole organism. This must be independent of any connection with the mother and when receiving only generally accepted medical treatment. If, in sum, these coordinated functions are not present, the fetus or prematurely born infant is biologically nonviable since it is incapable of being made able to exist as a self-sustaining whole organism independently of any connection with the mother. This may be the case even though some signs of life are apparent.

At this time (March, 1975) the following functions taken together constitute the minimal number of basic integrative physiologic functions:

1. The perfusion of tissues with adequate oxygen and the prevention of the increasing accumulation of carbon dioxide and/or lactic and other organic acids. This function consists of these components:

(a) inflation of the lungs with oxygen,

(b) transfer of oxygen across the alveolar membranes into the circulation and the elimination of carbon dioxide from the circulation into the expired gas, and

(c) cardiac contractions of sufficient strength and regularity to distribute oxygenated blood to tissues

and organs throughout the body and to eliminate organic acids from those tissues and organs.

2. Neurologic regulation of the components of the cardio-respiratory perfusion function, of the capacity to ingest nutrients, and of spontaneous and reflex muscle movements.

The foregoing minimal basic integrative physiologic functions cannot at present be separately assessed in the fetus or prematurely delivered infant in a consistent, reliable and exact manner. The absence of the sum of these minimal functions, however, can be assessed indirectly in a reasonable and reliable manner by measurement of weight and/or an estimation of gestational age, since specific weights and gestational ages correlate with a lack of potential for subsequent sustained extrauterine growth and development (survival). In this biologic sense, fetuses or prematurely delivered infants of less than 601 grams and/or of 24 weeks or less gestational age, may be considered nonviable. At these weights and gestational ages signs of life such as a beating heart, spontaneous respiratory movement, pulsation of the umbilical cord and spontaneous movement of voluntary muscles are not adequate in themselves to be used to determine the existence of these minimal basic integrative functions, e.g., the heart may continue to beat for as long as 30 minutes after removal from the body.

In addition, regardless of weight and gestational age, the minimal number of basic integrative physiologic functions to sustain subsequent extrauterine growth and development (survival) are not present in fetuses or prematurely delivered infants with:

1. severe malformations of the central nervous system, such as anencephaly;

2. severe grotesque multiple system malformations, such as cyclops; and

3. severe fetal asphyxia or anoxia when there has been no response to manual resuscitation according to the existing medical practice.

In contrast, a weight of 601 grams or more or gestational age of 25 weeks or more may indicate that the minimal number of basic integrative physiologic functions necessary for independent growth and development is present. Such a fetus or prematurely delivered infant may be considered biologically viable". Behrman-Rosen Report, pp. 66-69.

It is noteworthy that the most recent research on this subject, done by Dr. Dominick Purpura of Albert Einstein Medical School of Yeshiva University, who also is Director of the Rose Fitzgerald Kennedy Center, indicates that viability should be placed at the time when the fetus first develops the capacity for human intelligence. Dr. Purpura has questioned the current definition of viability, which reflects a view that the heart is the central organ of life. He states that, if the brain is given that role—as it increasingly has been in deciding when death occurs—then determination of viability of a fetus should be delayed by at least four weeks. Evidence for the development of brain life during the specific period of the 28th to 32nd week is based on correlation of results of brain wave, visual and other physiological tests with autopsy studies of premature infants that died despite treatment in an intensive care unit. See *New York Times,* May 9, 1975, p. 36.

The above data indicates that the complex determination of viability can be made only by a physician and that "certainty"—probably even "reasonable certainty"—is impossible. The data also makes it clear that a fetus of a gestational age of less than 24 weeks is not viable; although

viability is a complex concept including many factors other than gestational age, there were virtually no reports of infants of less than 24 weeks who survived. Indeed, of the thousands of cases studied, there were only two reports of infants surviving at less than 24 weeks, one a 21 week gestation weighing 879 grams and the other a 22 week gestation weighing 999 grams. "When the gestational ages of these infants were re-evaluated, it was noted that the gestational ages listed were taken from the obstetrical records of the referring hospital and were probably inaccurate. The birth weights do not correlate with the aforementioned gestational ages. According to the intra-uterine growth charts these infants were about 26 weeks and 26½ to 27 weeks respectively." Behrman-Rosen Report, p. 29.

With reference to abortions after 24 weeks, it is clear that the requirement that a physician "certify with reasonable medical certainty that the fetus is not viable" imposes on the physician an impossible task—in and of itself and for the further reason that whatever and however soundly based his "certification" may be, he is always susceptible of being second guessed by a jury and found guilty of a criminal offense.

B. "Viability" Is Impossible of Definition "with reasonable medical certainty."

Amici submit that a criminal statute must give physicians some clear guidelines so that they will know what conduct on their part is prohibited. As stated by Mr. Justice Marshall in *Grayned* v. *City of Rockford,* 408 U.S. 104 at 108-9 (1972):

> "It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are

not clearly defined. Vague laws offend several important values. First, because we assume that man is free to steer between lawful and unlawful conduct, we insist that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning. Second, if arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who apply them. A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an ad hoc and subjective basis, with the attendant dangers of arbitrary and discriminatory application. Third, but related, where a vague statute 'abut[s] upon sensitive areas of basic First Amendment freedoms,' it 'operates to inhibit the exercise of [those] freedoms.' Uncertain meanings inevitably lead citizens to '"steer far wider of the lawful zone" * * * than if the boundaries of the forbidden areas were clearly marked.'" [footnotes omitted].

Amici maintain that the statute's requirement of "certification with reasonable medical certainty" of non-viability is unconstitutionally vague and void on its face. In *amici's* opinion, in the present state of the art and the science of medicine, the state legislatures may not put physicians, as this statute does, in the position of performing all abortions after the first trimester at their peril.

Amici are, therefore, reluctant to put forward any definition of "viability" since the concept itself cannot be made the basis of a finding of guilt or innocence. However, if this Court considers that viability may be made the test of guilt or innocence in connection with the performance of

a constitutionally protected procedure, *amici* state that, based on the available data, the question of viability cannot be said to arise earlier than 24 weeks of gestation. *Amici* believe that a fetus should not be considered viable unless it has a statistically significant chance of survival. Therefore *amici* submit that legislation implementing this Court's decisions in *Roe* v. *Wade* and *Doe* v. *Bolton* which seeks to prohibit abortions after viability except to preserve the life or health of the mother must set the lowest limit at which viability may be deemed to occur at the 24-week period.

Of course, even at 24 weeks the data shows the likelihood of survival to be infinitesimal, with the survival statistics rising as pregnancy progresses until they reach 50% at approximately 28 weeks' gestation. See Behrman-Rosen Report, pp. 13-15. Figures 4, 5 and 6. *Amici* believe that an abortion performed prior to 24 weeks must be conclusively presumed to be of a non-viable fetus, that after 24 weeks, the physician doing the abortion procedure is the only one who can make the determination of viability, and that his determination must be final and not reviewable by a lay jury under threat of criminal penalties.

At least two courts have held that the determination of viability must be left for final determination by the physician doing the procedure. *Hodgson* v. *Anderson, supra; Wolfe* v. *Schroering*, 388 F. Supp. 631 (W.D. Ky. 1974).

In *Hodgson* v. *Anderson, supra*, a three-judge court declared unconstitutional many provisions of a Minnesota abortion statute including one that "during the second half

of its gestation period a fetus shall be considered potentially viable".

In *Wolfe* v. *Schroering, supra,* a three-judge Federal court upheld a section of a new Kentucky abortion statute which provides that once a fetus may reasonably be expected to have reached viability, no abortion shall be performed except in order to preserve the life or health of the mother. The court said:

> "Viability cannot be determined by the state; the decision is a medical one and must be left to the professional medical judgment of the woman's physician just as in any other medical procedure." 388 F.Supp. at 637.

Amici know of no other situation, *i.e.,* other than abortion, where any legislature, federal, state or local, has made the subject of a criminal penalty a diagnosis by a physician which turned out to be incorrect, nor has any legislature required a physician to "certify" any opinion of his "with reasonable medical certainty." If the Missouri statute here under attack is constitutional, even if applied only to abortions after 24 weeks, henceforth legislatures will presumably be free to require physicians, on pain of criminal penalties, to "certify with reasonable medical certainty" any other diagnosis, *e.g.* cancer, appendicitis, etc. On a parity of reasoning, if a physician "certified" that the patient did not have cancer, for example, and it turned out subsequently that he did, then a jury could find that the physician's diagnosis had not been made "with reasonable medical certainty" and send him to jail.

On September 4, 1975, a three-judge statutory panel of the United States District Court for the Eastern Dis-

trict of Pennsylvania declared unconstitutional the definition of viability in the Pennsylvania abortion statute. *Planned Parenthood Association* v. *Fitzpatrick,* Case No. 74-2440. That statute defined viability as "the capability of a fetus to live outside of the mother's womb albeit with artificial aid." 35 PS §6602 (Purdon's Supp. 1975-76). The statute imposed civil and criminal liability on a physician who either (1) failed to make a determination, prior to performing an abortion, that the fetus was not viable, or (2) having determined that the fetus might be viable, failed to exercise a high degree of care to preserve the life and health of the fetus in the process of performing the abortion. 35 PS §§6605(a); 6605(d) (Purdon's Supp. 1975-76).

The court held the definition of viability void for vagueness, saying:

> "We find that the Abortion Control Act's definition of viable is vague because it does not notify physicians as to what conduct on their part is prohibited." Slip opinion, p. 27

The court accepted the plaintiffs' argument that the vagueness of the definition of viability subjected them to possible arbitrary and discriminatory prosecution, stating in its opinion:

> "We believe that such a danger exists here for, without an objective standard to guide law enforcement officers, prosecutors and courts, physicians will be subject to prosecution controlled only by the subjective determinations of those charged with law enforcement. The possibility of such arbitrary enforcement certainly will, as plaintiffs contend, inhibit and deter physicians from performing abortions after a fetus has reached the gestational age of 20 weeks. Such a limitation prior to the 24th week of gestation

> is inconsistent with the fundamental right of a pregnant woman to obtain an abortion without regard to the potential for fetal life within the second trimester of the pregnancy. We find that the Supreme Court in *Roe* intended to set the lowest limit at which viability may be deemed to occur at the 24 week period. Accordingly, we hold that Section 2's definition of viability, Section 5(a) of the Act, which incorporates that definition, and Section 5(d), which imposes civil and criminal sanctions, are inconsistent with *Roe*, and are therefore unconstitutional." Slip opinion, pp. 28-29.

Amici urge this Court to declare unconstitutional the section of the Missouri statute defining viability on the basis of *Roe* v. *Wade, supra,* and for the reasons set forth above and in the *Fitzpatrick* case.

Conclusion

For the reasons stated in this brief and in the brief of the appellants, *amici* respectfully urge that this Court reverse the judgment of the three-judge court below insofar as it held constitutional Sections 2(2), 3(2), 3(3), 3(4), 7, 9, 10 and 11 of the Missouri abortion statute and affirm the judgment of that court insofar as it declared unconstitutional Section 6(1) of the Missouri abortion statute and enjoined enforcement of that section.

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